Home and Community Based Services Spinal Cord Injury (SCI)

Home and Community Based Services (HCBS) Spinal Cord Injury (SCI)

General Information

Waiver programs provide additional Health First Colorado benefits to specific populations who meet special eligibility criteria.

Level of care determinations are made annually by the case management agencies (aka Single-Entry Points). Members must meet financial, medical, and program criteria to access services under a waiver. The applicant must be at risk of placement in a nursing facility, hospital, or ICF/IID (Intermediate Care Facility for Individuals with an Intellectual Disability). To utilize waiver benefits, members must be willing to receive services in their homes or communities. A member who receives services through a waiver is also eligible for all basic Health First Colorado covered services except nursing facility and long-term hospital care. When a member chooses to receive services under a waiver, the services must be provided by certified Health First Colorado providers or by a Health First Colorado contracting managed care organization (MCO).

Each waiver has an enrollment limit. Applicants may apply for more than one waiver but may only receive services through one waiver at a time.

Prior Authorization Requests (PARs)

Unless otherwise noted, all HCBS services require prior approval before they can be reimbursed by the Health First Colorado. Case management agencies/single entry points complete the Prior Approval and/or Cost Containment requests for their specific programs according to instructions published in the regulations for the Department of Health Care Policy and Financing (the Department).

The telephone numbers are listed in Appendix A of the Appendices in the Provider Services Billing Manuals section.

For the Home and Community Based Services Spinal Cord Injury (HCBS-SCI) waiver, the following services must be submitted by the case management agency (CMA)/single entry point (SEP) to the Department for approval:

- All services above cost containment

Providers may contact the CMA/SEP for the status of the PAR or inquire electronically through the Health First Colorado Online Portal.

The CMAs/SEPs responsibilities include, but not limited to:

- Informing members and/or legal guardian of the eligibility process.
- Submitting a copy of the approved Enrollment Form to the County department of human/social services for a Health First Colorado member identification number.
- Developing the appropriate Prior Approval and/or Cost Containment Record Form of services and projected costs for approval.
- Submitting a copy of the Prior Authorization and/or Cost Containment document to the HCPF authorizing agent. A list of authorizing agents can be found by referring to Appendix D of the Appendices in the Provider Services Billing Manuals section.
- Assessing the member's health and social needs.

- Arranging for face-to-face contact with the member within 10 calendar days of receipt of the referral.
- Monitoring and evaluating services.
- Reassessing each member.
- Demonstrating continued cost effectiveness whenever services increase or decrease.

Approval of prior authorization does not guarantee Health First Colorado payment and does not serve as a timely filing waiver. Prior authorization only assures that the approved service is a medical necessity and is considered a benefit of the Health First Colorado. All claims, including those for prior authorized services, must meet eligibility and claim submission requirements (e.g., timely filing, provider information completed appropriately, required attachments included, etc.) before payment can be made.

Prior approvals must be completed thoroughly and accurately. If an error is noted on an approved request, it should be brought to the attention of the member's case manager for corrections. Procedure codes, quantities, etc., may be changed or entered by the member's case manager.

The authorizing agent or case management agency/single entry point is responsible for timely submission and distribution of copies of approvals to agencies and providers contracted to provide services.

PAR Submission

The HCBS-SCI forms are electronically filed via the "Bridge" which directly interfaces with the Colorado interChange System. Access to the Bridge is accomplished via the Medicaid Enterprise User Provisioning System (MEUPS) which can be found at https://home.co-meups.xco.dcs-usps.com/home/.

This is an electronic process. Paper documents should not be submitted. Note: If submitted to the Department's fiscal agent, the following correspondence will not be returned to case managers, outreach will not be performed to fulfill the requests, and all such requests will be recycled: 1) Paper PAR forms that do not clearly identify the case management agency in the event the form(s) need to be returned and/or 2) PAR revision requests not submitted on Department approved PAR forms, including typed letters with revision instructions. Should questions arise about what fiscal agent staff can process, please contact the appropriate Department Waiver manager.

PAR Form Instructional Reference Table

Field Label	Completion Format	Instructions
PA Number being revised		Conditional Complete if PAR is a revision. Indicate original PAR number assigned.
Revision	Check box ☐ Yes ☐ No	Required Check the appropriate box.
Client Name	Text	Required Enter the member's last name, first name and middle initial. Example: Adams, Mary A.

Field Label	Completion Format	Instructions
Client ID	7 characters, a letter prefix followed by six numbers	Required Enter the member's state identification number. This number consists of a letter prefix followed by six numbers. Example: A123456
Sex	Check box ☐ M ☐ F	Required Check the appropriate box.
Birthdate	6 numbers (MM/DD/YY)	Required Enter the member's birth date using MM/DD/YY format. Example: January 1, 2015 = 01/01/15.
Requesting Provider #	8 numbers	Required Enter the eight-digit Health First Colorado provider number of the requesting provider.
Client's County	Text	Required Enter the member's county of residence
Case Number (Agency Use)	Text	Optional Enter up to 12 characters, (numbers, letters, hyphens) which helps identify the claim or member.
Dates Covered (From/Through)	6 numbers for from date and 6 numbers for through date (MM/DD/YY)	Required Enter PAR start date and PAR end date.
Services Description	Text	Not required List of approved procedure codes for qualified and demonstration services.
Provider	Text	Optional Enter up to 12 characters to identify provider.
Modifier	2 Letters	Required The alphanumeric values in this column are standard and static and cannot be changed.
Max # Units	Number	Required Enter the number of units next to the services being requested for reimbursement.
Cost Per Unit	Dollar Amount	Required Enter cost per unit of service.
Total $ Authorized	Dollar Amount	Required The dollar amount authorized for this service automatically populates.

Field Label	Completion Format	Instructions
Comments	Text	Optional Enter any additional useful information. For example, if a service is authorized for different dates than in "Dates Covered" field, please include the HCPCS procedure code and date span here.
Total Authorized HCBS Expenditures	Dollar Amount	Required Total automatically populates.
Plus Total Authorized Home Health Expenditures (Sum of Authorized Home Health Services during the HCBS Care Plan Period)	Dollar Amount	Required Enter the total Authorized Home Health expenditures.
Equals Client's Maximum Authorized Cost	Dollar Amount	Required The sum of HCBS Expenditures + Home Health Expenditures automatically populates.
Number of Days Covered	Number	Required The number of days covered automatically populates.
Average Cost Per Day	Dollar Amount	Required The member's maximum authorized cost divided by number of days in the care plan period automatically populates.
CDASS Effective Date Monthly Allocation Amt.	Date (MM/DD/YY) Dollar Amount	Required for SCI, BI, CMHS and EBD Enter CDASS information (All CDASS information must be entered in the FMS web portal).
Immediately prior to HCBS enrollment, this client lived in a long-term care facility	Check box ☐ Yes ☐ No	Required Check the appropriate box.
Case Manager Name	Text	Required Enter the name of the Case Manager.
Agency	Text	Required Enter the name of the agency.
Phone #	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager.
Email	Text	Required Enter the email address of the Case Manager.
Date	6 Numbers (MM/DD/YY)	Required Enter the date completed.
Case Manager's Supervisor Name	Text	Required Enter the name of the Case Manager's Supervisor.

Field Label	Completion Format	Instructions
Agency	Text	Required Enter the name of the agency.
Phone #	10 Numbers 123-456-7890	Required Enter the phone number of the Case Manager's Supervisor.
Email	Text	Required Enter the email address of the Case Manager's Supervisor.
Date	6 Numbers (MM/DD/YY)	Required Enter the date of PAR completion.

SCI PAR Example

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

COLORADO Department of Health Care Policy & Financing

REQUEST FOR ADULT HOME AND COMMUNITY BASED SERVICES (HCBS) PRIOR APPROVAL AND COST CONTAINMENT

HCBS - Persons with a Spinal Cord Injury (SCI) Waiver

SCI- U1. SC

PA Number being revised:

Revision? ☐ Yes ☑ No

1. CLIENT NAME	2. CLIENT ID	3. SEX	4. BIRTHDATE
Client, Ima	A123456	☐ M ☑ F	7/7/1990

5. REQUESTING PROVIDER #	6. CLIENT'S COUNTY (SCI is only available in Adams, Arapahoe, Denver, Douglas, and Jefferson counties)	7. CASE NUMBER (AGENCY USE)	8. DATES COVERED		
00112233	Adams		From:	01/02/16	Through: 12/31/16

STATEMENT OF REQUESTED SERVICES

9. Description	10. Provider	11. Modifier	12. Max # Units	13. Cost Per Unit	14. Total $ Authorized	15. Comments:
S5105 Adult Day Services, Basic (U1, SC)						
S5105 Adult Day Services, Specialized (U1, SC)		TF				
S5151 Respite Care, ACF (U1, SC)						
97814 Alternative Therapies, Acupuncture (U1, SC)			24	$17.59	$422.16	
98942 Alternative Therapies, Chiropractic Care (U1, SC)			24	$17.59	$422.16	
97124 Alternative Therapies, Massage Therapy (U1, SC)			48	$13.80	$662.40	
T2025 Consumer Directed Attendant Support Services (CDASS) (Cent/ Unit) (U1, SC)			241087	$0.01	$2,410.87	
T2040 CDASS Per Member/ Per Month (PM/PM) (U1, SC) Fiscal Employer Agent (FEA) (U1, SC)						
S5165 Home Modifications (U1, SC)						
S5130 Homemaker (U1, SC)						
H0038 IHSS Health Maintenance Activities (U1, SC)						
S5130 IHSS Homemaker (U1, SC)		KX				
T1019 IHSS Personal Care (U1, SC)		KX				
T1019 IHSS Relative Personal Care (U1, SC)		HR, KX				
T2029 Medication Reminder, Install/Purchase (U1, SC)						
S5185 Medication Reminder, Monitoring (U1, SC)						
A0100 Non-Medical Transportation (NMT), Taxi (U1, SC)						
A0120 NMT, Mobility Van Mileage Band 1 (0-10 miles) (U1, SC)						
A0120 NMT, Mobility Van To and Mileage Band 1 (0-10 miles) (U1, SC)		HB				
A0130 NMT, Wheelchair Van Mileage Band 1 (0-10 miles) (U1, SC)						
A0130 NMT, Wheelchair Van to and Mileage Band 1 (0-10 miles) (U1, SC)		HB				
T1019 Personal Care (U1, SC)						
T1019 Personal Care, Relative (U1, SC)		HR				
S5160 Personal Emergency Response System (PERs) Install/Purchase (U1, SC)						
S5161 PERs, Monitoring (U1, SC)						
S5150 Respite Care, In Home (U1, SC)						
H0045 Respite Care, NF (U1, SC)						
A						
B						
C						
D						
E						
F						
G						
H						

16. TOTAL AUTHORIZED HCBS EXPENDITURES (SUM OF AMOUNTS IN COLUMN 14 ABOVE)	$3,917.59
17. PLUS TOTAL AUTHORIZED HOME HEALTH EXPENDITURES (SUM OF AUTHORIZED HOME HEALTH SERVICES DURING THE HCBS CARE PLAN PERIOD)- Excludes In-Home Support Services amounts	$0.00
18. EQUALS CLIENT'S MAXIMUM AUTHORIZED COST (HCBS EXPENDENITURES + HOME HEALTH EXPENDITURES)	$3,917.59
19. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)	365
20. AVERAGE COST PER DAY (Client's maximum authorized cost divided by number of days in the care plan period)	$10.73
A. Monthly State Cost Containment Amount	$6,084.00
B. Divided by 30.42 days = Daily Cost Containment Ceiling	$200.00

21. CDASS (amounts must match client's allocation worksheet)	Effective Date:		Monthly Allocation Amt:	$0.00	Monthly Admin Fee:	$0.00

22. Immediately prior to HCBS enrollment, this client lived in a long term care facility? ☐ Yes ☑ No

23. CASE MANAGER NAME	24. AGENCY	25. PHONE #	26. EMAIL	27. DATE
Jane Doe	SCI Agency	303-333-3333	Jane.Doe@SCIAgency.com	01/01/2016
23A. CASE MANAGER SIGNATURE:				
28. CASE MANAGER'S **SUPERVISOR** NAME	29. AGENCY	30. PHONE #	31. EMAIL	32. DATE
John Doe	SCI Agency	303-333-3333	John.Doe@SCIAgency.com	01/01/2016
28A. CASE MANAGER'S **SUPERVISOR** SIGNATURE:				

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

33. CASE PLAN: ☐ Approved Date: ☐ Denied Date: Return for correction- Date:

34. REGULATION(S) upon which Denial or Return is based:

35. DEPARTMENT APPROVAL SIGNATURE: 36. DATE:

1 of 2 HCBS- SCI Revision: 11/17/14

Consumer Directed Attendant Support Services (CDASS)

For members authorized to receive CDASS, case managers will need to enter the data into one of the web-based systems in addition to sending a PAR to the Department's fiscal agent. Members have the option to receive Financial Management Services (FMS) from one (1) of three (3) FMS vendors:

- ACES$
- Morning Star
- Public Partnerships, LLC (PPL)

Claim Submission

Refer to the General Provider Information manual for general billing information, as well as claim submission information..

Persons with a Spinal Cord Injury (HCBS-SCI)

The Home and Community Based Services Spinal Cord Injury (HCBS-SCI) waiver program provides a variety of services to qualified members with spinal cord injury as an alternative to inpatient hospital or nursing facility placement. Members meeting program eligibility requirements are determined functionally eligible for HCBS-SCI waiver by the case manager.

Procedure Code Table

Providers may bill the following procedure codes for HCBS-SCI services:

Procedure Code Table			
Description	**Procedure Code + Modifier(s)**		**Units**
Adult Day Services, Basic	S5105	U1, SC	1 unit = 3-5 hours
Adult Day Services, Specialized	S5105	U1, SC, TF	1 unit = 3-5 hours
Complementary and Integrative Health, Acupuncture	97814	U1, SC	1 unit = 15 minutes
Complementary and Integrative Health, Chiropractic Care	98942	U1, SC	1 unit = 15 minutes
Complementary and Integrative Health, Massage Therapy	97124	U1, SC	1 unit = 15 minutes
Consumer Directed Attendant Support Services (CDASS)	T2025	U1, SC	Negotiated by case manager through prior authorization.
CDASS Per Member/Per Month (PM/PM)	T2040	U1, SC	Negotiated by case manager through prior authorization.
Home Modifications	S5165	U1, SC	1 unit = per service
Homemaker	S5130	U1, SC	1 unit = 15 minutes
IHSS Health Maintenance Activities	H0038	U1, SC	1 unit = 15 minutes
IHSS Homemaker	S5130	U1, SC, KX	1 unit = 15 minutes

Procedure Code Table				
IHSS Personal Care		T1019	U1, SC, KX	1 unit = 15 minutes
IHSS Relative Personal Care		T1019	U1, SC, HR, KX	1 unit = 15 minutes
Medication Reminder, Install/Purchase		T2029	U1, SC	Negotiated by case manager through prior authorization.
Medication Reminder, Monitoring		S5185	U1, SC	Negotiated by case manager through prior authorization.
Non-Medical Transportation (NMT), Taxi		A0100	U1, SC	1 unit = one-way trip
NMT, Mobility Van	Mileage Band 1 (0-10 miles)	A0120	U1, SC	1 unit = one-way trip
NMT, Mobility Van To and From Adult Day	Mileage Band 1 (0-10 miles)	A0120	U1, SC, HB	1 unit = one-way trip
NMT, Wheelchair Van	Mileage Band 1 (0-10 miles)	A0130	U1, SC	1 unit = one-way trip
NMT, Wheelchair Van To and From Adult Day	Mileage Band 1 (0-10 miles)	A0130	U1, SC, HB	1 unit = one-way trip
Personal Care		T1019	U1, SC	1 unit = 15 minutes
Personal Care, Relative		T1019	U1, SC, HR	1 unit = 15 minutes
Personal Emergency Response System (PERs) Install/Purchase		S5160	U1, SC	Negotiated by case manager through prior authorization.
PERS, Monitoring		S5161	U1, SC	Negotiated by case manager through prior authorization.
Respite Care, Alternative Care Facility (ACF)		S5151	U1, SC	1 unit = 1 day
Respite Care, In Home		S5150	U1, SC	1 unit = 15 minutes
Respite Care, Nursing Facility (NF)		H0045	U1, SC	1 unit = 1 day

Paper Claim Reference Table

The following paper form reference table gives required and/or conditional fields for the paper CMS 1500 claim form for SCI claims:

CMS Field #	Field Label	Field is?	Instructions
1	**Insurance Type**	Required	Place an "X" in the box marked as Medicaid.
1a	**Insured's ID Number**	Required	Enter the member's Health First Colorado seven-digit Medicaid ID number as it appears on the Medicaid Identification card. Example: A123456.
2	**Patient's Name**	Required	Enter the member's last name, first name, and middle initial.
3	**Patient's Date of Birth / Sex**	Required	Enter the member's birth date using two digits for the month, two digits for the date, and two digits for the year. Example: 070180 for July 1, 1980. Place an "X" in the appropriate box to indicate the sex of the member.
4	**Insured's Name**	Not Required	
5	**Patient's Address**	Not Required	
6	**Patient's Relationship to Insured**	Not Required	
7	**Insured's Address**	Not Required	
8	**Reserved for NUCC Use**		
9	**Other Insured's Name**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
9a	**Other Insured's Policy or Group Number**	Not Required	
9b	**Reserved for NUCC Use**		
9c	**Reserved for NUCC Use**		
9d	**Insurance Plan or Program Name**	Not Required	
10a-c	**Is Patient's Condition Related to?**	Not Required	
10d	**Reserved for Local Use**		
11	**Insured's Policy, Group or FECA Number**	Not Required	
11a	**Insured's Date of Birth, Sex**	Not Required	
11b	**Other Claim ID**	Not Required	
11c	**Insurance Plan Name or Program Name**	Not Required	
11d	**Is there another Health Benefit Plan?**	Not Required	
12	**Patient's or Authorized Person's signature**	Required	Enter "Signature on File", "SOF", or legal signature. If there is no signature on file, leave blank or enter "No Signature on File". Enter the date the claim form was signed.

CMS Field #	Field Label	Field is?	Instructions
13	**Insured's or Authorized Person's Signature**	Not Required	
14	**Date of Current Illness Injury or Pregnancy**	Not Required	
15	**Other Date**	Not Required	
16	**Date Patient Unable to Work in Current Occupation**	Not Required	
17	**Name of Referring Physician**	Conditional	
18	**Hospitalization Dates Related to Current Service**	Not Required	
19	**Additional Claim Information**	Conditional	
20	**Outside Lab?** **$ Charges**	Not Required	
21	**Diagnosis or Nature of Illness or Injury**	Required	Enter at least one but no more than twelve diagnosis codes based on the member's diagnosis/condition. Enter applicable ICD indicator to identify which version of ICD codes is being reported. 0 ICD-10-CM **HCBS** HCBS may use R69
22	**Medicaid Resubmission Code**	Conditional	List the original reference number for resubmitted claims. When resubmitting a claim, enter the appropriate bill frequency code in the left-hand side of the field.

CMS Field #	Field Label	Field is?	Instructions
			7 Replacement of prior claim 8 Void/Cancel of prior claim This field is not intended for use for original claim submissions.
23	**Prior Authorization**	Not Required	
24	**Claim Line Detail**	Required	The paper claim form allows entry of up to six detailed billing lines. Fields 24A through 24J apply to each billed line. **Do not enter more than six lines of information** on the paper claim. If more than six lines of information are entered, the additional lines will not be entered for processing. Each claim form must be fully completed (totaled). **Do not file continuation claims** (e.g., Page 1 of 2).
24A	**Dates of Service**	Required	The field accommodates the entry of two dates: a "From" date of services and a "To" date of service. Enter the date of service using two digits for the month, two digits for the date and two digits for the year. Example: 010116 for January 1, 2016 From To **01 01 16** | | | | | | Or From To **01 01 16 01 01 16** Span dates of service From To **01 01 16 01 31 16** Single Date of Service: Enter the six-digit date of service in the "From" field. Completion of the "To field is not required. Do not spread the date entry across the two fields. Span billing: permissible if the same service (same procedure code) is provided on consecutive dates.

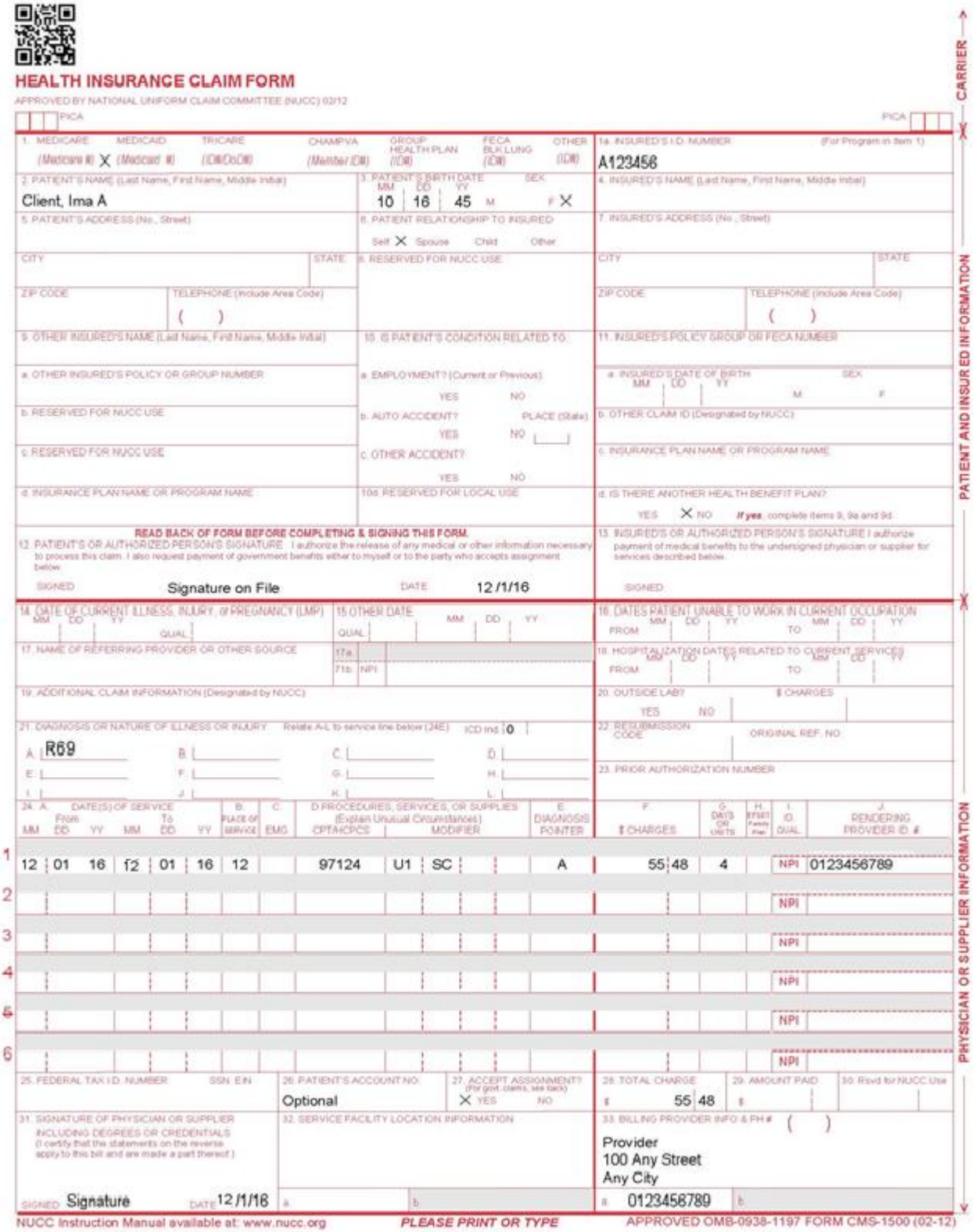
CMS Field #	Field Label	Field is?	Instructions
24B	**Place of Service**	Required	Enter the Place of Service (POS) code that describes the location where services were rendered. The Health First Colorado accepts the CMS place of service codes. 11 Office 12 Home **NOTE:** Use POS Code 12 (Home) for Alternative Care Facility, Adult Day Program, or Respite in the Facility
24C	**EMG**	Not Required	
24D	**Procedures, Services, or Supplies**	Required	Enter the SCI procedure code that specifically describes the service for which payment is requested. **SCI** Refer to the SCI procedure code tables.
24D	**Modifier**	Required	Enter the appropriate procedure-related modifier that applies to the billed service. Up to four modifiers may be entered when using the paper claim form.
24E	**Diagnosis Pointer**	Required	Enter the diagnosis code reference letter (A-L) that relates the date of service and the procedures performed to the primary diagnosis. At least one diagnosis code reference letter must be entered. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. This field allows for the entry of 4 characters in the unshaded area.
24F	**$ Charges**	Required	Enter the usual and customary charge for the service represented by the procedure code on the detail line. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.

CMS Field #	Field Label	Field is?	Instructions
			Some CPT procedure codes are grouped with other related CPT procedure codes. When more than one procedure from the same group is billed, special multiple pricing rules apply. The base procedure is the procedure with the highest allowable amount. The base code is used to determine the allowable amounts for additional CPT surgical procedures when more than one procedure from the same grouping is performed. Submitted charges cannot be more than charges made to non-Health First Colorado covered individuals for the same service. Do not deduct Health First Colorado co-payment or commercial insurance payments from the usual and customary charges.
24G	**Days or Units**	Required	Enter the number of services provided for each procedure code. Enter whole numbers only- do not enter fractions or decimals.
24G	**Days or Units**	General Instructions	A unit represents the number of times the described procedure or service was rendered. Except as instructed in this manual or in Health First Colorado bulletins, the billed unit must correspond to procedure code descriptions. The following examples show the relationship between the procedure description and the entry of units. **Home & Community Based Services** Combine units of services for a single procedure code for the billed time period on one detail line. Dates of service do not have to be reported separately. Example: If forty units of personal care services were provided on various days throughout the month of January, bill the personal care procedure code with a From Date of 01/03/XX and a To Date of 01/31/XX and 40 units.
24H	**EPSDT/Family Plan**	Not Required	
24I	**ID Qualifier**	Not Required	

CMS Field #	Field Label	Field is?	Instructions
24J	**Rendering Provider ID #**	Required	In the shaded portion of the field, enter the NPI of the Health First Colorado provider assigned to the individual who actually performed or rendered the billed service. This number cannot be assigned to a group or clinic.
25	**Federal Tax ID Number**	Not Required	
26	**Patient's Account Number**	Optional	Enter information that identifies the member or claim in the provider's billing system. Submitted information appears on the Remittance Advice (RA).
27	**Accept Assignment?**	Required	The accept assignment indicates that the provider agrees to accept assignment under the terms of the payer's program.
28	**Total Charge**	Required	Enter the sum of all charges listed in field 24F. Do not use commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
29	**Amount Paid**	Not Required	
30	**Reserved for NUCC Use**		
31	**Signature of Physician or Supplier Including Degrees or Credentials**	Required	Each claim must bear the signature of the enrolled provider or the signature of a registered authorized agent. A holographic signature stamp may be used if authorization for the stamp is on file with the fiscal agent. An authorized agent or representative may sign the claim for the enrolled provider if the name and signature of the agent is on file with the fiscal agent. Each claim must have the date the enrolled provider or registered authorized agent signed the claim form. Enter the date the claim was signed using two digits for the month, two digits for the date and two digits for the year. Example: 010216 for January 2, 2016.

CMS Field #	Field Label	Field is?	Instructions
			Unacceptable signature alternatives: Claim preparation personnel may not sign the enrolled provider's name. Initials are not acceptable as a signature. Typed or computer printed names are not acceptable as a signature. "Signature on file" notation is not acceptable in place of an authorized signature.
32	**32- Service Facility Location Information** **32a- NPI Number** **32b- Other ID #**	Conditional	Complete for services provided in a hospital or nursing facility in the following format: 1st Line Facility Name 2nd Line Address 3rd Line City, State and ZIP Code 32a- NPI Number Enter the NPI of the service facility (if known).
33	**33- Billing Provider Info & Phone #** **33a- NPI Number** **33b- Other ID #**	Required	Enter the name of the individual or organization that will receive payment for the billed services in the following format: 1st Line Name 2nd Line Address 3rd Line City, State and ZIP Code 33a- NPI Number Enter the NPI of the billing provider

HCBS-SCI Claim Example



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) X | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): A123456

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Client, Ima A

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 45 | SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE: 12/1/16

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a | 17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A R69 B C D

E F G H

I J K L

22. RESUBMISSION CODE | ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	12 01 16	12 01 16	12		97124	U1 SC		A	55 48	4		NPI	0123456789
2												NPI	
3												NPI	
4												NPI	
5												NPI	
6												NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. Optional

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 55 48

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature DATE 12/1/16

32. SERVICE FACILITY LOCATION INFORMATION

a b

33. BILLING PROVIDER INFO & PH # ( )

Provider
100 Any Street
Any City

a 0123456789 b

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

Spinal Cord Injury (SCI) Waiver Services

The HCBS-SCI waiver program provides a variety of services to eligible members with a spinal cord injury as an alternative to inpatient hospital and nursing facility placement. Members meeting program eligibility requirements are certified by the case management agency/single entry point as medically eligible for this HCBS waiver program. This waiver offers all of the following services:

- **Adult Day Services** - Services furnished between three (3) – five (5) or more hours per day on a regularly scheduled basis, for one or more days per week. Services provided in an outpatient setting, encompassing both health and social services needed to assure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care would be furnished as component parts of this service if such services are not being provided in the participant's home.
- **Complementary and Integrative Health Services** - Services are limited to Acupuncture, Chiropractic Care, and Massage Therapy. Services are to be delivered under direction of a care plan approved by a Complementary and Integrative Health Service Provider. There is a yearly cap that allows for no more than 204 units of a single service and no more than 408 total units of any combination of services.
- **Electronic Monitoring/Personal Emergency Response Systems** - An electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Monitoring of the device is included in the PERS service. The response center is staffed by trained professionals.
- **Homemaker** - Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker. Provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
- **Home Modification** - Specific modifications, adaptations or improvements in an eligible member's existing home setting which, based on the member's medical condition are necessary to ensure the health, welfare and safety of the member, enable the member to function with greater independence in the home, are required because of the member's illness, impairment or disability, as documented on the ULTC-100.2 form and the care plan and prevents institutionalization of the member. There is a lifetime cap of $14,000 per member.
- **Medication Reminder** - Medication reminders are devices, controls, or appliances which enable an individual at high risk of institutionalization to increase their abilities to perform activities of daily living, such as medication administration. Medication reminders shall include devices or items that remind or signal the member to take prescribed medications. Medication reminders may include other devices necessary for the proper functioning of such items, and may also include durable and non-durable medical equipment not available as a State plan benefit
- **Personal Care** - Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. These services may include assistance with preparation of meals but does not include the cost of the meals themselves. When specified in the service plan, this service may also include such housekeeping chores as bed making, dusting and vacuuming. Services are incidental to the care furnished or are essential to the health and welfare of the individual, rather than the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step parent), or to an individual by the person's spouse.
- **Relative Personal Care** - Personal Care providers may be members of the individual's family. The number of Health First Colorado (Colorado's Medicaid Program) personal care units for

provided by any single member of the member's family shall not exceed the equivalent of 444 personal care units per annual certification. Payment will not be made for services furnished to an individual by an individual's spouse employed by a Personal Care agency.

- **Respite** - Services provided to an eligible member on a short-term basis because of the absence or need for relief of those persons normally providing the care. The unit of reimbursement shall be a unit of one day for care provided in an Alternative Care Facility. Individual respite providers shall bill according to an hourly rate or daily institutional rate, whichever is less.
- **Non-Medical Transportation** - Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170 (a) (if applicable), and shall not replace them. Non-Medical Transportation is limited to two (2) round-trips per week. Trips to and from Adult Day programs are not subject to this cap.

The HCBS-SCI program also offers the following participant-directed service delivery options:

- **Consumer Directed Attendant Support Services (CDASS)** - CDASS is a service delivery option that offers HCBS-SCI members the opportunity to direct services that assist an individual in accomplishing activities of daily living including personal care, homemaker and health maintenance tasks. Members may also designate an authorized representative to direct these activities on their behalf. The member, or the authorized representative, is responsible for hiring, training, recruiting, setting wages, scheduling, and in other ways managing the attendant.
- **In-Home Support Services (IHSS**) - IHSS includes health maintenance activities, support for activities of daily living or instrumental activities of daily living, personal care service and homemaker services. Such services are provided under the direction of the member, or an authorized representative who is designated by the member. Additionally, IHSS providers are required to provide the core independent living skills.

Timely Filing

For more information on timely filing policy, including the resubmission rules for denied claims, please see the General Provider Information manual.

Home and Community Based Services (HCBS) Spinal Cord Injury (SCI) Manual Revisions Log

Revision Date	Section/Action	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016 Please refer to Archive.*	*All*	*HPE (now DXC)*
12/27/2016	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*2, 3, 14*	*HPE (now DXC)*
1/10/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_3.xlsx*	*Multiple*	*HPE (now DXC)*
1/19/2017	*Updates based on Colorado iC Stage Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
5/22/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*7*	*DXC*
6/26/2018	*Updated billing (claims submission) and timely filing*	*8, 22*	*HCPF*
6/28/18	*Updated claim submission*	*8*	*HCPF*

Note: *In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above are the page numbers on which the updates/changes occurred.*